



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TEXAS HEALTH LLC  
PO BOX 600324  
DALLAS TX 75360-0324

#### **Respondent Name**

DALLAS ISD

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-10-3059-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "CPT code 97799 was pre-authorized. Texas health is a CARF accredited facility and this procedure is \$125.00 per unit under the TWCC Medical Fee Guideline."

**Amount in Dispute:** \$20,000.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "According to the October 1, 2009 Decision and Order the compensable injury of July 13, 2000 does not extend to depression and adjustment disorder with anxiety." "Therefore, no allowance is recommended for any of the disputed dates of service for procedure codes 90801 (psychiatric diagnostic interview examination), 96100 (psychological testing), 90806 (individual psychotherapy), 90880 (hypnotherapy), and 90889 (preparation of report of patient's psychiatric status). Enclosed are medical records indicating the psychological diagnosis was 296.34 for major depressive disorder and 309.24 for adjustment disorder with anxiety." "No allowance is recommended for the chronic pain program billed with procedure code 97799CPA as treatment was rendered for depression and anxiety."

**Response Submitted by:** Argus, 9101 LBJ Freeway, Suite 600, Dallas, TX 75243-2055

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2005 April 22, 2005 April 25, 2005 April 27, 2005 April 28, 2005 April 29, 2005 May 2, 2005 May 3, 2005 May 4, 2005 May 5, 2005 May 16, 2005	CPT code 97799-CP-CA (x8 hours)	\$1000.00/day	\$0.00

May 19, 2005 May 20, 2005 May 25, 2005 May 26, 2005 May 27, 2005 May 31, 2005 June 1, 2005 June 2, 2005			
June 3, 2005	CPT code 97799-CP-CA (x8 hours)	\$1000.00/day	\$562.50
TOTAL		\$20,000.00	\$562.50

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Division rule at 28 TAC §134.203 titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.204, *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §134.600, requires preauthorized for specific treatments and services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 13, 2005, June 7, 2005, June 8, 2005, June 24, 2005, June 29, 2005, June 30, 2005

- W11A-Entitlement to benefits.
- Reimbursement for this service(s) is being denied based on Notice of Disputed Claim or Controversy by Carrier.

Explanation of benefits dated November 5, 2009

- 193N-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Claim is disputed.

#### **Issues**

1. Does a compensability issue exist in this dispute?
2. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement for CPT code 97799-CP-CA?

#### **Findings**

1. A Benefit Review Conference was held on January 8, 2002 that found that the compensable injury of July 13, 2000 did not extend to and include injuries to the claimant's cervical spine or lumbar spine. This decision was appealed by claimant and requestor.

The Division scheduled a Contested Case Hearing on May 21, 2009, to which the Claimant did not attend. The Contested Case Hearing was reset and held on October 1, 2009 that found that the compensable injury of July 13, 2000 did not extend to depression and adjustment disorder with anxiety.

A review of the submitted medical bills indicates that the disputed treatment was for ICD-9 codes "718.01-Articular cartilage disorder of the shoulder region"; and "718.92 unspecified derangement of the upper arm joint".

The July 13, 2000 compensable injury was to the claimant's left shoulder and upper extremity; therefore, according to the submitted billing the disputed treatment was for the compensable injury.

2. The Division finds that the chronic pain management program rendered from April 21, 2005 through June 2, 2005 was a duplicate dispute found in Medical Fee Dispute Resolution Tracking number M5-06-0447-02;

therefore, these services will not be addressed in this dispute.

3. On June 3, 2005 the requestor billed CPT code 97799-CP-CA for a chronic pain management program.

28 Texas Administrative Code §133.307(g)(3)(B), requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." On April 26, 2012, the Division contacted the requestor's representative, Judith Guerra, and requested copies of medical records relevant to the dispute. The requestor submitted the following documentation to support billed service:

DATE	REPORT	TIME	NUMBER OF HOURS - PER 28 TEXAS ADMINISTRATIVE CODE §134.204(H)(5)(B)	TOTAL
June 3, 2005	Chronic Pain Management Note	11-12	1	4:50
	Psychotherapy Session	12-1	1	
	Therapeutic Group Note	3-4	1	
	Activity Flow Sheet	95	1.5	

28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP-CA for 4.5 hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is \$125.00 per hour x 4.5 hours = \$562.50. The carrier paid \$0.00. Therefore, the difference between the MAR and amount paid is \$562.50. This amount is recommended for reimbursement.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is \$562.50.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$562.50 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
5/10/2012  
Date

## **YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**